Medicaid Miscellaneous Pharmacy
Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P.O. Box 3210
Auburn, AL 36823-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

Nursing home resident ❒ Yes

PRESCRIBER INFORMATION

Prescribing practitioner _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing practitioner signature Date

DISPENSING PHARMACY INFORMATION

Dispensing pharmacy _____ Provider # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____ Drug Requested _____

DRUG/CLINICAL INFORMATION

❒ Drug request – Complete this section ***Required for all requests*** Quantity per month _____

❒ Compounding Professional Fee – Complete items marked ◆ and next section PA Refills: 0 1 2 3 4 5 Other _____

◆ Diagnosis _____ ICD-9 Code* _____

◆ Diagnosis _____ ICD-9 Code* _____

◆ ❒ Initial Request ◆ ❒ Renewal

◆ Medical justification _____

◆ ❒ Additional medical justification attached. **❒ EPSDT Referral form attached**

***See Instruction Sheet, Section 4**

COMPOUNDING SPECIFIC INFORMATION

Compounding Ingredients (Ing.)

Ing. Name _____ Ing. Name _____

Ing. Name _____ Ing. Name _____

If more ingredients are required, attach additional sheets.

Compounding Time

Units Requested (in minutes)

_____

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____
Reviewer's Signature

_____
Response Date/Hour